

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT SETON SPECIALTY HOSPITAL, INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for 2 (two) State hospital complaints.</p> <p>Complaint: #IN00102080 Unsubstantiated; lack of sufficient evidence.</p> <p>Complaint: #IN00102301 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility: #003350</p> <p>Date: 7/31/2012 - 8/2/2012</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>St.Vincent Seton Specialty Hospital-Indianapolis is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.4-1, Governing Body, Indiana State Hospital Licensure Rules.</p> <p>QA: cloughlin 09/19/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

YHJX11

If continuation sheet 1 of 1